

who had otherwise no symptoms or signs of kidney disease. He was able to produce such an albuminuria by placing patients, who ordinarily had no albuminuria, in a lordotic position while in bed, the albumin disappearing when the position was altered. He was able to increase the amount of albumin by placing patients with renal disease in a lordotic position, and he was able to reproduce it in patients in whom the albumin had disappeared altogether, simply by forcing such a position. A more marked degree of lordosis is necessary to produce an albuminuria in a healthy individual than in one with nephritis. From a series of observations of the albuminuria of scarlet fever patients he concludes that it is frequent, usually slight, generally lasts but a short time, but may return during the course of convalescence several times; there may or may not be an organic sediment; it may appear with the patient lying quietly in bed or after he rises; it may be associated with other sequels or may be the only remaining injury of the disease. In all convalescents, however, the same albuminuria and acetic acid precipitate could be produced by inducing a lordosis, and in no patient in whom the lordotic experiment was negative were there ever symptoms of a pathological or functional kidney disturbance noted. The cause of the albuminous excretion after scarlet fever is more of a functional than pathological nature. The anatomical change is probably a slight "catarrh of the uriniferous tubules." The disease is benign and disappears usually in a few days to weeks, the patient resting quietly in bed.

OBSTETRICS.

UNDER THE CHARGE OF

EDWARD P. DAVIS, A.M., M.D.,

PROFESSOR OF OBSTETRICS IN THE JEFFERSON MEDICAL COLLEGE, PHILADELPHIA.

The Treatment of Placenta Prævia.—SELLHEIM (*Monats. f. Geb. u. Gyn.*, 1909, xxix, 1) writes an open letter to Professor Martin urging the claims of extraperitoneal suprasymphyseal Cesarean section in the treatment of placenta prævia. Sellheim urges that the tedious uncertain methods of vaginal dilatation, with their mortality and morbidity, should be abandoned in placenta prævia in favor of modern surgical operations. He urges as a reason for this the great improvement in mortality and morbidity and the more prompt and lasting convalescence of the mother. The method of Cesarean delivery which Sellheim urges consists in opening the abdominal wall just above the pubes, taking care to avoid the peritoneum; the emptied urinary bladder is carried strongly downward or else above the brim of the pelvis, while the peritoneal sac is pushed upward; the operator thus seeks to avoid opening the peritoneal cavity. The lower uterine cervix, and, if necessary, the cervix, is incised sufficiently to deliver the child. If there is sufficient dilatation, the placenta may be expressed through the vagina, or, if such is not the case, it is manually removed. Should there be a tendency to

hemorrhage, the uterus is tamponed with iodoform gauze, which is subsequently removed through the vagina. If the case is septic the wound may be left open, the edges of the uterine wound being sutured to the margins of the abdominal wound. The uterus may then be drained with gauze. A uterine fistula is thus established, which is allowed to close spontaneously as the patient recovers.

The Toxicoses of Pregnancy.—FELLNER (*Monatschr. f. Geb. u. Gyn.*, 1909, xxix, 1) calls attention to the disturbances in the secretory nerves occasioned by pregnancy. Should toxemia develop, the nervous system becomes greatly disturbed. Fellner has endeavored to ascertain the exact factor in eclampsia which produces these psychic developments. He believes that the placenta plays an important part, because in several cases he has observed a cessation of the psychosis following the removal of retained placental tissue. He believes that an exaggeration of physiological processes, rather than the development of an entirely new pathological condition, causes these conditions. He draws attention to some of the phenomena of menstruation as similar to eclampsia and also the characteristic pain of osteomalacia.

The Management of Labor in Contracted Pelves is the title of an interesting book by BÜRGER, assistant in the first obstetric clinic in Vienna. This book, so far as we know, has not yet been translated into English. The material studied was 4240 cases of contracted pelvis occurring among 49,375 patients, a percentage of 8.5. The book is written from Pinard's standpoint, but we may hope that obstetric science will reach that point where no child will be sacrificed in the interest of the mother. Contracted pelvis are divided into four classes, the true conjugate of the fourth being 6.5 cm. Cases of atypical contraction are not considered, as each case must be considered upon its individual merits. Cases complicated by eclampsia, placenta prævia, or in which the child weighed less than four and one-half pounds, are also excluded. The general plan of treatment employed has been an expectant one. If the conjugata vera measured 8 cm., except in simple flat pelvis, spontaneous labor was not expected. Symphysiotomy was performed for conjugata vera between 9 and 7 cm. The highest application of the forceps was always tentative and never forcible. The lowest forceps application was made only when danger threatened the mother or child. In breech cases the finger in the groin was the only method of making traction advisable.

The percentage of spontaneous deliveries was high. In primigravidae with flat pelvis, when the true conjugate was between 8.5 cm. and 7.6 cm., there were 56.4 per cent. of spontaneous deliveries. With primigravidae having generally contracted pelvis, with the same true conjugate, there were 62.7 per cent. of spontaneous deliveries. When the true conjugate was from 7.5 to 6.5 cm., the percentage of spontaneous deliveries varied from 9.95 to 18. In general, varying with the degree of contraction, there were in all kinds of contracted pelvis, from 89 to 9.9 per cent. of spontaneous deliveries. Bürger thinks that prophylactic version should seldom be performed. Premature labor was induced in only 0.6 per cent. of all cases of pelvic contraction, and 47 per cent. of the infants were lost.

Bürger believes that the induction of premature labor should be reserved for cases in which the patient has borne previously large and well-developed children, where some of the difficulties in delivery can undoubtedly be overcome by the mother. If the induction of labor is not followed by spontaneous delivery, vaginal delivery is rarely indicated, and in highly contracted pelvis should never be attempted. Symphysiotomy is replaced by hebotomy. This operation was done twenty-three times, with no maternal mortality, and with the loss of one child. If both mother and child are to be saved, there is no question that Cesarean section is the preferable operation. Hebotomy is less dangerous for the mother, and in selected cases not much more dangerous for the child. Bürger believes that in the future premature labor and prophylactic version will very rarely be performed. Hebotomy will take the place of some cases in which Cesarean section is now performed.

GYNECOLOGY.

UNDER THE CHARGE OF

J. WESLEY BOVÉE, M.D.,

PROFESSOR OF GYNECOLOGY IN THE GEORGE WASHINGTON UNIVERSITY, WASHINGTON, D. C.

The Ureters after the Radical Abdominal Operation for Carcinoma of the Uterus.—W. WEIBEL (*Zeitschr. f. Geb. u. Gyn.*, 1908, lxii, 184), as assistant to Wertheim, reports the occurrence of ureteral fistulae in 24 out of 400 cases operated upon for carcinoma of the uterus. In 3 cases there was a fistula of each ureter. It is believed that the fistulae in all cases arose from necrosis due to extensive dissection interfering with the blood supply of the uterus. Actual injury to the ureters during operation occurred 8 times in the first 200 and 3 times in the last 200 operations, and was in nearly every instance observed at the time and successfully remedied. The fistulae appeared never earlier than the seventh nor later than the eighteenth day after operation, and were usually observed during the second week. Spontaneous healing occurred in 13 out of the 24 cases, beginning in one instance as early as the second week after the appearance of the fistula and taking place in another case as late as the fourth month. Usually spontaneous closure took place between the third and twelfth weeks; 2 of the 3 cases of bilateral fistula healed spontaneously. A nephrectomy was performed in 7 of the 11 cases in which spontaneous healing did not occur after long intervals, and is the operation recommended under such conditions. Cystoscopic examinations in cases of fistula followed by spontaneous healing showed in most cases a marked prolongation of the interval between contractions of the affected ureter as compared with the normal one, and in many cases a diminution in the intensity of the stream of urine. No other symptoms were observed in such patients.